PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) RENEWABILITY OF GRANT.—

(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.

(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) IN GENERAL.—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an ''Exchange'') for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a ''SHOP Exchange'') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both

qualified individuals and qualified small employers, but only

if the Exchange has adequate resources to assist such individuals and employers.
(c) RESPONSIBILITIES OF THE SECRETARY.—
(1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—
(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;
(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;
(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;
(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or
(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;
(E) implement a quality improvement strategy described in subsection (g)(1);
(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;
(G) utilize the standard format established for presenting health benefits plan options; and
(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is

offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) INTERNET PORTALS.—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or costsharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

(6) ENROLLMENT PERIODS.—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such

periods under part D of title XVIII of the Social Security Act; and
(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).
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(d) REQUIREMENTS.—
(1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.
(2) OFFERING OF COVERAGE.—
(A) IN GENERAL.—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.
(B) LIMITATION.—
(i) IN GENERAL.—An Exchange may not make available any health plan that is not a qualified health plan.
(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).
(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—
(A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).
(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—
(i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).
(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).
(4) FUNCTIONS.—An Exchange shall, at a minimum—
(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;
(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans

may obtain standardized comparative information on such plans;
(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);
(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use

of the uniform outline of coverage established under section 2715 of the Public Health Service Act;
(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;
(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any costsharing reduction under section 1402;
(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—
(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
(I) transfer to the Secretary of the Treasury—
(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;
(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—
(I) the employer did not provide minimum essential coverage; or
(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective

date of such cessation);
(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and
(K) establish the Navigator program described in subsection (i).
(5) FUNDING LIMITATIONS.—
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(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.
(B) PROHIBITING WASTEFUL USE OF FUNDS.—In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.
(6) CONSULTATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—
(A) health care consumers who are enrollees in qualified health plans;
(B) individuals and entities with experience in facilitating enrollment in qualified health plans;
(C) representatives of small businesses and selfemployed individuals;
(D) State Medicaid offices; and
(E) advocates for enrolling hard to reach populations.
(7) PUBLICATION OF COSTS.—An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.
(e) CERTIFICATION.—
(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—
(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and
(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—
(i) on the basis that such plan is a fee-for-service plan;
(ii) through the imposition of premium price controls; or
(iii) on the basis that the plan provides treatments

necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) PREMIUM CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under

section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT.—

(A) IN GENERAL.—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY.—In this paragraph, the term ''eligible entity'' means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—
(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and
(D) the implementation of wellness and health promotion activities.
(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).
(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).
(h) QUALITY IMPROVEMENT.—
(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—
(A) a hospital with greater than 50 beds only if such hospital—
(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and
(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or
(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.
(2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).
(3) ADJUSTMENT.—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).
(i) NAVIGATORS.—
(1) IN GENERAL.—An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) ELIGIBILITY.—
(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.
(B) TYPES.—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused

nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—
(i) are capable of carrying out the duties described in paragraph (3);
(ii) meet the standards described in paragraph (4); and
(iii) provide information consistent with the standards developed under paragraph (5).
(3) DUTIES.—An entity that serves as a navigator under a grant under this subsection shall—
(A) conduct public education activities to raise awareness of the availability of qualified health plans;
(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;
(C) facilitate enrollment in qualified health plans;
(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.
(4) STANDARDS.—
(A) IN GENERAL.—The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—
(i) be a health insurance issuer; or
(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.
(6) FUNDING.—Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.
(j) APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.
(k) CONFLICT.—An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.
(a) CHOICE.—
(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.
(2) QUALIFIED EMPLOYERS.—
(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.
(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.
(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.
(c) SINGLE RISK POOL.—
(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.
(2) SMALL GROUP MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.
(3) MERGER OF MARKETS.—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.
(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.
(d) EMPOWERING CONSUMER CHOICE.—
(1) CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.—Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and
(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.
(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.
(3) VOLUNTARY NATURE OF AN EXCHANGE.—
(A) CHOICE TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to restrict the choice of
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a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.
(B) PROHIBITION AGAINST COMPELLED ENROLLMENT.—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.
(C) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).
(D) MEMBERS OF CONGRESS IN THE EXCHANGE.—
(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—
(I) created under this Act (or an amendment made by this Act); or
(II) offered through an Exchange established under this Act (or an amendment made by this Act).
(ii) DEFINITIONS.—In this section:
(I) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.
(II) CONGRESSIONAL STAFF.—The term ''congressional staff'' means all full-time and parttime employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.
(4) NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph

(1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

(1) QUALIFIED INDIVIDUALS.—In this title:

(A) IN GENERAL.—The term ''qualified individual'' means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) QUALIFIED EMPLOYER.—In this title:

(A) IN GENERAL.—The term ''qualified employer'' means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) EXTENSION TO LARGE GROUPS.—

(i) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term ''qualified employer'' shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan

in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS.—An Exchange shall be subject to annual audits by the Secretary.

(4) PATTERN OF ABUSE.—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to implement under this title or any other Act.

(6) APPLICATION OF THE FALSE CLAIMS ACT.—

(A) IN GENERAL.—Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) GAO OVERSIGHT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study

of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—
(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;
(2) any significant observations regarding the utilization and adoption of Exchanges;
(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges; and
(4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) ESTABLISHMENT OF STANDARDS.—
(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—
(A) the establishment and operation of Exchanges (including SHOP Exchanges);
(B) the offering of qualified health plans through such Exchanges;
(C) the establishment of the reinsurance and risk adjustment programs under part V; and
(D) such other requirements as the Secretary determines appropriate.
The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.
(2) CONSULTATION.—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.
(b) STATE ACTION.—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—
(1) the Federal standards established under subsection (a); or
(2) a State law or regulation that the Secretary determines implements the standards within the State.
(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—
(1) IN GENERAL.—If—

(A) a State is not an electing State under subsection (b); or
(B) the Secretary determines, on or before January 1, 2013, that an electing State—
(i) will not have any required Exchange operational by January 1, 2014; or
(ii) has not taken the actions the Secretary determines necessary to implement—
(I) the other requirements set forth in the standards under subsection (a); or
(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;
the Secretary shall (directly or through agreement with a notfor-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.
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(2) ENFORCEMENT AUTHORITY.—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).
(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.
(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—
(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.
(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) ESTABLISHMENT OF PROGRAM.—
(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO–OP) program.
(2) PURPOSE.—It is the purpose of the CO–OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.
(b) LOANS AND GRANTS UNDER THE CO–OP PROGRAM.—
(1) IN GENERAL.—The Secretary shall provide through the CO–OP program for the awarding to persons applying to become

qualified nonprofit health insurance issuers of—
(A) loans to provide assistance to such person in meeting its start-up costs; and
(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.
(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—
(A) IN GENERAL.—In awarding loans and grants under the CO–OP program, the Secretary shall—
(i) take into account the recommendations of the advisory board established under paragraph (3);
(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and
(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance

issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.
(B) STATES WITHOUT ISSUERS IN PROGRAM.—If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.
(C) AGREEMENT.—
(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO–OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—
(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and
(II) any requirements contained in the agreement for such person to receive such loan or grant.
(ii) RESTRICTIONS ON USE OF FEDERAL FUNDS.—
The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—
(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or
(II) for marketing.
Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.
(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable

period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—
(I) 110 percent of the aggregate amount of loans and grants received under this section; plus
(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.
The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.
(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO–OP program and begin the distribution of amounts awarded under such loans and grants.
(3) ADVISORY BOARD.—

(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.
(B) RULES RELATING TO APPOINTMENTS.—
(i) STANDARDS.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.
(ii) ORIGINAL APPOINTMENTS.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.
(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.
(D) PAY AND REIMBURSEMENT.—
(i) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.
(ii) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.
(E) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.
(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.
(c) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—
(1) IN GENERAL.—The term ''qualified nonprofit health insurance issuer'' means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation;
(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and
(C) that meets the other requirements of this subsection.
(2) CERTAIN ORGANIZATIONS PROHIBITED.—An organization shall not be treated as a qualified nonprofit health insurance issuer if—
(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or
(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.
(3) GOVERNANCE REQUIREMENTS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless—

(A) the governance of the organization is subject to a majority vote of its members;
(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and
(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.
(4) PROFITS INURE TO BENEFIT OF MEMBERS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.
(5) COMPLIANCE WITH STATE INSURANCE LAWS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).
(6) COORDINATION WITH STATE INSURANCE REFORMS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).
(d) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—
(1) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO–OP program under this section may establish a private purchasing council to enter into collective

purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) COUNCIL MAY NOT SET PAYMENT RATES.—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) CONTINUED APPLICATION OF ANTITRUST LAWS.—

(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term ''antitrust laws'' has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to

the extent that such section 5 applies to unfair methods of competition.

(e) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) LIMITATIONS ON SECRETARY.—

(1) IN GENERAL.—The Secretary shall not—

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) APPROPRIATIONS.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

(h) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

''(29) CO–OP HEALTH INSURANCE ISSUERS.—

''(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO–OP program under

such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

''(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

''(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

''(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

''(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

''(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''.

(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

''(m) ADDITIONAL INFORMATION REQUIRED FROM CO–OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

''(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

''(2) The amount of reserves on hand.''.

(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking ''paragraph (3) or (4)'' and inserting ''paragraph (3), (4), or (29)''.

(i) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.

(a) VOLUNTARY NATURE.—

(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for nonparticipation.
(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN.—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.
(3) STATE OPT OUT.—
(A) IN GENERAL.—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.
(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.
(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—
(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges
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in States that elect to opt out as provided for in subsection (a)(3)), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.
(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term ''community health insurance option'' means health insurance coverage that—
(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;
(B) provides high value for the premium charged;
(C) reduces administrative costs and promotes administrative simplification for beneficiaries;
(D) promotes high quality clinical care;
(E) provides high quality customer service to beneficiaries;
(F) offers a sufficient choice of providers; and
(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).
(3) ESSENTIAL HEALTH BENEFITS.—
(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).
(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.
(C) CREDITS.—
(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner

as an individual who is enrolled in a qualified health plan.

(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health

insurance option for a service otherwise not included as an essential health benefit.

(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) COST SHARING.—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) PREMIUMS.—

(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.

(B) APPLICABLE RULES.—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

(6) REIMBURSEMENT RATES.—

(A) NEGOTIATED RATES.—The Secretary shall negotiate rates for the reimbursement of health care providers for

benefits covered under a community health insurance option.
(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange.
(C) INNOVATION.—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.
(7) SOLVENCY AND CONSUMER PROTECTION.—
(A) SOLVENCY.—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.
(B) MINIMUM REQUIRED.—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.

(C) CONSUMER PROTECTIONS.—The consumer protection laws of a State shall apply to a community health insurance option.
(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.—
(A) IN GENERAL.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the ''NAIC''), may promulgate regulations to establish additional requirements for a community health insurance option.
(B) APPLICABILITY.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.
(c) START-UP FUND.—
(1) ESTABLISHMENT OF FUND.—
(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the ''Health Benefit Plan Start-Up Fund'' (referred to in this section as the ''Start-Up Fund''), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.
(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—
(i) pay the start-up costs associated with the initial operations of a community health insurance option; and

(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered.

(2) USE OF START-UP FUND.—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).

(3) PASS THROUGH OF REBATES.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

(4) REPAYMENT.—

(A) IN GENERAL.—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).

(B) SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined to

be a for-profit entity by the Secretary, such entity shall be—

(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and

(ii) permanently ineligible to offer a qualified health plan.

(d) STATE ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and

(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.

(e) AUTHORITY TO CONTRACT; TERMS OF CONTRACT.—
(1) AUTHORITY.—
(A) IN GENERAL.—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.
(B) REQUIREMENTS APPLY.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—
(i) shall meet the criteria established under paragraph (2); and
(ii) shall receive an administrative fee under paragraph (7).
(C) LIMITATION.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.
(D) REFERENCE.—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a ''contracting administrator''.

(2) QUALIFIED ENTITY.—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—
(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;
(B) be a nonprofit entity for purposes of offering such option;
(C) meet the solvency standards applicable under subsection (b)(7);
(D) be eligible to offer health insurance or health benefits coverage;
(E) meet quality standards specified by the Secretary;
(F) have in place effective procedures to control fraud, abuse, and waste; and
(G) meet such other requirements as the Secretary may impose.
Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.
(3) TERM.—A contract provided for under paragraph (1)

shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.

(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).

(5) AUDITS.—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) REVOCATION.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

(7) FEE FOR ADMINISTRATION.—

(A) IN GENERAL.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) NON-RENEWAL.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.

(8) LIMITATION.—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).

(f) REPORT BY HHS AND INSOLVENCY WARNINGS.—

(1) IN GENERAL.—On an annual basis, the Secretary shall

conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) RESULT.—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.

(3) SUBMISSION OF PLAN AND PROCEDURE.—

(A) IN GENERAL.—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

(B) PROCEDURE.—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a medicare funding warning.

(g) MARKETING PARITY.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1324. LEVEL PLAYING FIELD.

(a) IN GENERAL.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—

(1) guaranteed renewal;

(2) rating;

(3) preexisting conditions;

(4) non-discrimination;

(5) quality improvement and reporting;

(6) fraud and abuse;

(7) solvency and financial requirements;

(8) market conduct;

(9) prompt payment;

(10) appeals and grievances;

(11) privacy and confidentiality;

(12) licensure; and
(13) benefit plan material or information.